Durable Medical Equipment (DME) and Medical Supplies Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to durable medical equipment (DME) providers who provide DME and medical supplies to members of the CarePartners of Connecticut plans selected above.

Note: Audit and disclaimer information is located at the end of this document.

Policy

CarePartners of Connecticut covers medically necessary DME and medical supplies up to the benefit maximum[1], in accordance with the member's benefits and CMS guidelines, as applicable. CarePartners of Connecticut will determine whether it is appropriate to purchase or rent equipment for members.

Definition

DME is equipment that meets all of the following criteria:

- Can withstand repeated use
- Is primarily and customarily used to serve a medical purpose
- Generally, is not useful to a person in the absence of an illness or injury
- Is appropriate for use in the home

Medical supplies are disposable or nonreusable items that generally do not contain the mechanical components commonly found in DME.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

Referral/Prior Authorization/Notification Requirements

Certain DME items require prior authorization through the CarePartners of Connecticut Precertification Operations Department, while others may require notification to another entity. The DME provider is responsible for obtaining the practitioner's order/prescription for any requested item(s). Prescriptions/orders should include quantity and refill information, as applicable. As a condition of payment, it is the responsibility of the **rendering** provider to obtain prior authorization or notification, as applicable. If authorization or notification is not obtained/approved, the claim will be denied. For more information, refer to the Referral, Authorization and Notification Policy.

Refer to the Prior Authorization and Inpatient Notification List for CarePartners of Connecticut to identify specific items, services, and supplies that have prior authorization and/or notification requirements.

With the exception of PAP therapy and related supplies, providers should fax all requests for coverage of DME to the Precertification Operations Department at 857-304-6463.

[1] Authorized medical supplies, respiratory equipment/supplies (excluding PAP therapy, nebulizers and related supplies), insulin pumps and related diabetic supplies are not applied to the benefit maximum.

Oral Enteral Formula

CarePartners of Connecticut members must obtain oral enteral formula through a contracted DME supplier.

Medical Supplies

Required medical/dressing supplies can be obtained by the member from a contracting DME provider with a provider order.

Home health agencies providing services to members may order medical supplies directly from a CarePartners of Connecticut contracting DME provider, who will then submit a claim to CarePartners of Connecticut. CarePartners of Connecticut requires provider documentation for medical supplies. A written, signed and dated order must be received by the supplier for an item to be covered.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Modifiers

Tufts Health Plan requires all industry standard modifiers on DME, respiratory and medical supply claims. Claims submitted without complete and appropriate modifiers will be denied. Refer to the DME Medicare Administrative Contractor (MAC) for a list of modifiers appropriate for DME and medical supply claims.

Providers must bill capped rental items with the appropriate rental modifiers, as outlined below. Do **not** report modifier RR throughout the rental period.

- KH (Initial claim, either rent [first month] or purchase)
- KI (rental months 2-3)
- KJ (rental months 4-13)

Note: When billing for new and used equipment purchases, providers must use the NU (new) and UE (used) modifiers as appropriate.

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules.

Orders/prescriptions for DME items and supplies that exceed regulatory (e.g., CMS) or policy limits will not be compensated.

CarePartners of Connecticut does not routinely compensate for the following:

Compression Gradient Stockings

- A6530, A6533 or A6536 when more than four pairs are billed within a calendar year
- A6545 when more than four pairs are billed in a calendar year

Diabetic Shoes, Inserts, and Modifications

- Diabetic shoe inserts/modifications when billed more than six units within a calendar year
- Diabetic shoe inserts/modifications when billed with orthopedic footwear
- Therapeutic shoes, inserts, or modifications for diabetics unless a diagnosis of diabetes mellitus is also on the claim

Diabetic Shoes

- A5500-A5513 when billed without right (RT) or left (LT) modifier.
- Diabetic shoes when billed for more than two units within a calendar year.
- Orthopedic shoe inserts, heel stabilizer, orthopedic shoe lift elevation per inch, orthopedic shoe wedges, orthopedic shoe additions, and miscellaneous orthopedic shoe, addition modification or transfer when billed with diabetic footwear.

Nebulizers

- Compounded inhalation solutions (J7604, J7607, J7609, J7610, J7615, J7622, J7624, J7627, J7628, J7629, J7632, J7634, J7635, J7636, J7637, J7638, J7640, J7641, J7642, J7643, J7645, J7647, J7650, J7657, J7660, J7667, J7670, J7676, J7680, J7681, J7683, J7684, J7685)

Osteogenic Stimulators

- E0748 (electrical osteogenesis stimulator) if billed without a diagnosis of post-surgical arthrodesis status.

Ostomy Supplies

- Sleeves, bags or a cone/catheter with brush if billed with an ostomy irrigation kit, as these are included in the ostomy irrigation kit.

Oxygen and Oxygen Equipment

- E0424, E0439, E1390, E1391 when billed more than once a month in any combination
- E0433, E1390, E1391, K0738 when billed with modifier MS more than once every six months in any combination by any provider
- E0441, E0442, or E0443, E0444, K0742 when billed more frequently than once every month

Place of Service Restrictions

- DME items when billed by a Medicare Administrative Contractor (MAC) provider and the place of service is not 01 (Pharmacy), 04 (Homeless Shelter), 09 (Prison), 12 (Home), 13 (Assisted Living Facility), 14 (Group Home), 33 (Custodial Care Facility), 54 (Intermediate Care Facility/Mentally Retarded), 55 (Residential Substance Abuse Treatment Facility), 56 (Psychiatric Residential Treatment Center), 65 (End Stage Renal Disease [ESRD] Treatment Facility [POS valid for Parenteral Nutritional Therapy]).

Pneumatic Compression Devices

- Pneumatic appliances (sleeves) if the corresponding compressor is not also paid within the same month by any provider

Respiratory Assist Devices

- E0471 (respiratory assist device) if billed without a diagnosis of obstructive sleep apnea
- mutually exclusive respiratory assist devices when billed the same date of service or in a month

Suction Pumps and Supplies

- A9272 (wound suction, disposable)
- A4216, A4217 when billed with A4328 when A4605, A4624 has not been billed in the same month

Transcutaneous Electrical Nerve Stimulation (TENS)

- A4450, A4452, A4455, A4556, A4557, A4558, A4630 if billed by any provider on the same date or during the same month as E0720 or E0730
- A4557 billed within a year of E0720 or E0730

Ventricular Assist Devices

- Ventricular assist device accessories if billed more frequently than once per year, unless billed with modifier RA or RB

Walkers

- E0155 if billed the same day or within one month of E0130, E0135, E0140, E0148

Wheelchair Options and Accessories

- Manual wheelchair accessories if billed with a power wheelchair
- Power wheelchair accessories if billed with a manual wheelchair
- E2358, E2360, E2362, E2364, E2372, or E2367
- Wheelchair options or accessories when billed without modifier KX on the same date of service as a power wheelchair base

Additional Resources

- Orthotic and Prosthetic Payment Policy
- Sleep Studies Payment Policy

Document History

- November 2024: Annual policy review; no changes
- June 2024: Clarified reimbursement limitations for certain DME items and supplies
- May 2024: Added existing requirements for DME and required capped rental modifiers
- November 2023: Annual policy review; administrative edits
- November 2022: Annual policy review; administrative updates

- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021; policy reviewed; clarified existing claim edits and prior authorization content
- May 2019: Added claim edit for DME modifiers, effective for dates of service on or after July 1, 2019
- April 2019: Removed frequency limitations for B4088, A4362, A4425, A5063
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.